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Palliative Cancer Care Guidelines

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Palliative Care Standards

The World Health Organization (WHO) describes palliative care as services designed to

prevent and relieve suffering for patients and families facing life-threatening illness, through early management of pain and other physical, psychosocial, and spiritual problems. [1]

Growing recognition of palliative care as an integral aspect of cancer treatment, with the ability to improve quality of life and prevent unnecessary hospital admissions and the use of health

services, especially when instituted early in the course of disease, has prompted the development of a range of guidelines concerning palliative cancer care.{ref1 [2] The American Society

for Clinical Oncology (ASCO) recommends considering the combination of palliative care with standard oncology care early in the course of treatment for patients with metastatic cancer

and/or a high symptom burden. [3] Specific recommendations are as follows:

The time to start palliative care is as soon as a patient's cancer becomes advanced

For newly diagnosed patients with advanced cancer, the Expert Panel suggests early palliative care involvement within 8 weeks after diagnosis

Inpatients and outpatients with

advanced cancer should receive dedicated palliative care services early in the disease course concurrent with active treatment.

According to ASCO, essential components

of palliative care may include the following [3] :

Building rapport and relationships with patients and family caregivers

Managing symptoms, distress, and functional

status (eg, pain, dyspnea, fatigue, sleep disturbance, mood, nausea, constipation)

Exploration of understanding and education about illness and prognosis

Clarification of

treatment goals

Assessment and support of coping needs (eg, provision of dignity therapy)

Assistance with medical decision making

Coordination with other care providers

Provision of referrals to other care providers as indicated

ASCO recommendations on delivery of palliative care are as follows [3]

For patients with cancer who have high

symptom burden and/or unmet physical or psychosocial needs, outpatient cancer care programs should provide and use dedicated resources (palliative care clinicians) to deliver

palliative care services to complement existing program tools.

For patients with early or advanced cancer who will be receiving care from family caregivers in the outpatient setting,

providers (eg, nurses, social workers) may initiate caregiver-tailored palliative care support, which could include telephone coaching, education, referrals, and face-to-face meetings.

Telephone support may be offered for family caregivers who may live in rural areas or are unable to travel to the clinic.

The National Comprehensive Cancer Network (NCCN)

concurs and includes the following additional recommendations [4] :

All cancer patients should be repeatedly screened for palliative care needs, beginning with their initial diagnosis and

thereafter at intervals as clinically indicated

Palliative care should be initiated by the primary oncology team and then augmented by collaboration with palliative care experts

All health care

professionals should receive education and training to develop palliative care knowledge, skills, and attitudes

An interdisciplinary team of palliative care specialists should be

available to provide consultation or direct care to patients and/or families as requested or needed

Quality of palliative care should be monitored by institutional quality

improvement programs

The NCCN recommends assessment by the oncology team for patients whose screening confirms the presence of one or more of the following [4] :

Uncontrolled symptoms

Moderate-to-severe distress related to cancer diagnosis and/or cancer therapy

Serious comorbid physical, psychiatric, and psychosocial

conditions

Metastatic solid tumors

Life expectancy ≤6 mo

Patient or family concerns about the course of disease and decision-making

Patient/family requests for palliative care

Indicators of short life expectancy include the following:

Poor performance status – Eastern Cooperative Oncology Group (ECOG) score ≥3 or Karnofsky Performance Status

(KPS) score ≤50

Persistent hypercalcemia

Brain or cerebrospinal fluid metastasis

Delirium

Superior vena cava syndrome

Spinal cord

compression

Cachexia

Malignant effusions

Palliative stenting or venting gastrostomy

Cancer Pain

National Comprehensive Cancer Network (NCCN)

guidelines identify general principles of pain management and provide specific recommendations for assessment, management, and reassessment of cancer pain in adults. Major

recommendations include the following [5] :

Consider interventions in the context of patient-specific goals for comfort, function, and safety

Patients with an acute

pain crisis may be candidates for hospital admission to achieve goals for comfort and function

Identify pain related to an oncologic emergency

For pain not related to

an oncologic emergency, discriminate opioid-tolerant patients from opioid-naïve patients (ie, those with versus those without long-term exposure to opioids)

Assessment

Assessment recommendations are as follows:

All patients should be screened for pain at every contact

Pain intensity must be quantified and the

quality characterized by the patient

Comprehensive pain assessment for persisting pain or new pain should be performed to determine the etiology, pathophysiology,

specific cancer pain syndrome, and patient goals for comfort and function

Management

Cancer pain management guidelines from the European Society for

Medical Oncology (ESMO) follow the WHO strategy of a sequential three-step analgesic ladder from non-opioids to weak opioids to strong opioids, gauged to pain intensity. [8] ESMO

recommendations for choice of analgesics according to pain severity are as follows:

Mild – Acetaminophen (paracetamol) and/or a nonsteroidal anti-inflammatory drug (NSAID); those agents

are also effective as adjuncts for treating more severe pain, at least in the short term and unless contraindicated

Mild to moderate – Weak opioids such as codeine, tramadol, and

dihydrocodeine, in combination with non-opioid analgesics

Moderate to severe - Oral morphine

ESMO guidelines note that although oral administration is advocated, patients

presenting with severe pain that needs urgent relief should be treated and titrated with parenteral opioids, usually subcutaneous or intravenous. [8]

ESMO recommendations

regarding alternative strong opioids include the following:

Oral hydromorphone or oxycodone (immediate-release and modified-release) and oral methadone are effective alternatives to

oral morphine; however, methadone should be initiated by physicians with experience and expertise in its use

Transdermal fentanyl and transdermal buprenorphine are best

reserved for patients whose opioid requirements are stable, and are usually the treatment of choice for patients who are unable to swallow, have poor tolerance of morphine, r poor

compliance

Buprenorphine has a role in the analgesic therapy of patients with renal impairment and undergoing hemodialysis treatment

Opioid switching to improve pain relief

and/or drug tolerability is not supported by high-quality evidence but is frequently used in clinical practice; it requires requires familiarity with equianalgesic doses of the different opioids

For pain related to an oncologic emergency, such as bone fracture, infection, or obstruction, the NCCN recommends treating the pain directly in addition to providing specific treatment for

the underlying condition (eg, surgery, steroids, radiation therapy, antibiotics). For pain not related to an oncologic emergency, NCCN recommendations vary according to whether

the patient is opioid naïve or opioid tolerant. The U.S. Food and Drug Administration (FDA) defines opioid tolerance as receiving, for 1 week or longer, one of the following [6]:

60 mg oral morphine/day

25 mcg transdermal fentanyl/hour

30 mg oral oxycodone/day

8 mg oral hydromorphone/day

25 mg oral

oxymorphone/day

An equianalgesic dose of another opioid

For opioid-naïve patients, the NCCN recommends the following non–oncologic emergency pain

management [5] :

Provide psychosocial support, including education of the patient and family

Reevaluate at each contact

Consider adjuvant analgesics for specific

pain syndromes

Optimize integrative interventions

Provide a prophylactic bowel regimen for patients receiving opioid analgesics

Severe pain: rapidly titrate a short-acting

opioid

Moderate pain: titrate a short-acting opioid

Mild pain: Consider nonsteroidal anti-inflammatory drugs (NSAIDs) or acetaminophen or slower titration of a

short-acting opioid

For opioid-tolerant patients who have breakthrough pain of intensity ≥4 (on a scale of 0-10) or whose goals of pain control and function are not met, management is as

follows [5] :

Administer a rescue dose of a short-acting opioid, equivalent to 10 -20% of the total long-acting or regularly schedule oral opioid dose taken in the previous 24 hours

Assess efficacy and adverse effects every 60 minutes for oral opioids and every 15 minutes for IV opioids

If pain assessment is unchanged or increased, increase the rescue dose by 50-100%

If the pain score decreases, repeat the opioid dose and reassess at 60 minutes for oral opioids and 15 minutes for IV opioids

If the pain score remains unchanged after two to three

cycles, consider changing the route of administration from oral to IV or explore alternative management strategies

If the pain score decreases to 0-3, give the current effective

dose as needed over 24 hours before proceeding to subsequent management strategies

Ongoing need for repeated rescue doses may indicate a need for adjustment of the

regularly scheduled opioid dose

Consider rapidly acting transmucosal fentanyl for brief episodes of incident pain not attributed to inadequate dosing of around-the-clock opioid

Subsequent management is based on the continued pain rating score and includes the following:

Regular doses of opioids, with rescue doses as needed

Management of

constipation

Social support and education for patients and families

For ongoing care, if an acceptable level of comfort and function has been achieved and the patient’s 24-hour

opioid requirement is stable, convert to an extended-release oral medication (if feasible) or other extended-release formulation (e, transdermal fentanyl).

In 2012 the European Association for

Palliative Care (EAPC) updated its guidelines for the use of opioid analgesics to treat cancer pain and provided the following recommendations [7] :

For mild to moderate pain not controlled by

NSAIDs, a step II oral opioid (codeine or tramadol) may be added; a step III opioid (eg, morphine or oxycodone) may also be considered

There is no preference among oral morphine,

oxycodone, or hydromorphone as first-choice step III opioids for moderate to severe pain

Transdermal fentanyl and buprenorphine are alternatives to oral opioids for patients

unable to swallow

Patients experiencing inadequate relief and severe adverse effects with a step III opioid may benefit from switching to an alternative opioid

Subcutaneous delivery

is the preferred alternative for patients unable to receive opioids orally or transdermally; IV infusion should be considered when subcutaneous administration is

contraindicated; IV infusion is preferred for opioid titration when rapid pain control is needed

Dyspnea

The NCCN guidelines for treatment of dyspnea in cancer

patients are based on estimates of the patient's life expectancy. [4] For patients with a life expectancy of years to months to weeks, the NCCN recommends assessment of

symptom intensity followed by treatment of underlying causes or comorbid conditions with measures such as the following:

Chemotherapy and/or radiation therapy

Procedure to reduce or

remove cardiac, pleural or abdominal fluid

Bronchoscopic therapy

Bronchodilators, diuretics, steroids, antibiotics, or transfusions

Anticoagulants for pulmonary emboli

For symptomatic relief, the following interventions may be used, as appropriate:

Oxygen therapy for hypoxia

Educational, psychosocial, and emotional support for

patients and family

Nonpharmacologic therapies including fans, cooler temperatures, stress management, relaxation therapy, and comfort measures

If the patient is opioid naïve, morphine; if

dyspnea is not relieved by morphine and is associated with anxiety, add benzodiazepines

Noninvasive positive-pressure ventilation (ie, continuous positive airway pressure [CPAP], biphasic positive airway

pressure [BiPAP]) if clinically indicated for a severe reversible condition

For patients with a life expectancy of weeks to days, the following measures may be used, in addition to the

interventions listed above:

When assessing symptom intensity, use physical signs of distress as potential indications of dyspnea in noncommunicative patients

Withhold, withdraw, or initiate a time-limited trial of mechanical ventilation as indicated by patient and family preferences, prognosis, and reversibility

Provide sedation as needed

Provide guidance for patient and family regarding dying and respiratory failure

Provide emotional and spiritual support

If fluid overload is a contributing factor, interventions include

the following:

Decrease/discontinue enteral or parenteral fluid

Consider low-dose diuretics

If opioid naïve, morphine

Benzodiazepines

Scopolamine to reduce excessive secretions

The only treatment for dyspnea recommended in the Oncology Nursing Society (ONS) guidelines is parenteral or oral immediate-release opioids. For

patients with a life expectancy of years to months to weeks, the ONS deemed the following interventions “likely to be effective“ [9] :

Temporary ventilator support for severe,

reversible conditions

Oxygen therapy

Benzodiazepines for anxiety

Increasing ambient airflow directed at the face or nose

Providing cooler temperatures

Promoting relaxation and stress reduction

Providing educational, emotional, and psychosocial support for patients and family caregivers, and referring to other disciplines as

appropriate

For patients with a life expectancy of weeks to days, the ONS recommendations are as follows:

Reduce excessive secretions with scopolamine,

hyoscyamine, or atropine

Implement oxygen therapy, if the patient reports subjective relief with it

Institute sedation as needed

Discontinue fluid

support; consider low-dose diuretics if fluid overload may be a contributing factor

Anorexia/Cachexia Guidelines for the management of anorexia/cachexia in patients with advanced

cancer have been issued by the NCCN and the European Palliative Care Research Collaborative (EPCRC). The NCCN guidelines are based on estimates of the patient's life expectancy. [4] For

patients with a life expectancy of years to months, the recommendations are as follows:

Evaluate the severity of weight loss

Treat reversible causes

– Early satiety;

symptoms that interfere with food intake (eg, depression, pain, constipation, nausea/vomiting, fatigue, dyspnea)

Modify medications that interfere with intake

Consider possible endocrine disorders – Hypogonadism, thyroid dysfunction, metabolic abnormalities (eg, increased calcium)

Consider appetite stimulant – Megestrol acetate (should be used

with caution due to increased risk of blood clots, edema; death occurs in one of every 23 patients, prednisone

Consider exercise program

Consider consultation with a nutritionist

Consider enteral and parenteral feeding as appropriate

For patients with a life expectancy of months to weeks to days, the NCCN recommends first determining the importance of the

symptoms to patient and family; if considered important, the anorexia/cachexia can be treated with megestrol acetate. Further recommendations are as follows:

Focus should be on patient goals and preferences

Provide emotional support

Treat depression, if appropriate

Provide education and support to patient and

family regarding the emotional aspects of withdrawal of nutritional support

Finally, inform the patient and family of the natural history of advanced cancer, including the following:

Absence of hunger and thirst is normal

Nutritional support may not be metabolized

There are risks associated with artificial nutrition and hydration, including

fluid overload, infection, and hastened death

Symptoms such as dry mouth can be treated with local measures (eg, mouth care, small amounts of liquids)

Withholding or withdrawal of enteral

or parenteral nutrition is ethically permissible; it will not exacerbate symptoms and may improve some symptoms

The EPCRC guidelines focus on refractory cachexia in patients

with advanced cancer, which it defines as “a stage where reversal of weight loss is no longer possible due to very advanced or rapidly progressive cancer unresponsive to anti-cancer therapy.” The

recommendations in the guidelines are aimed at alleviating the consequences and complications of cachexia and eating-related distress of patients and families and include the

following [10] :

Educate patient and family to minimize eating-related distress; counsel them about weight loss–related distress and end-of-life issues

Enteral nutrition

therapy may be partially effective for selected patient groups

The burden of parenteral nutrition will outweigh any benefits in the majority of patients

The use of thalidomide

is not recommended

The use of cannabinoids is not recommended

Progestins should be considered for patients with anorexia as a major distressing symptom

Steroids may be given for short periods (at most 2 weeks); longer duration may increase the burden on the patient from side effects and may cause a deterioration in muscle strength

Distress Management

The NCCN guidelines for distress management include recommendations for ongoing screening, monitoring, documentation, and treatment of distress

throughout all stages of cancer treatment. Screening for distress using the Distress Thermometer and Problem Checklist should be conducted at the initial visit and at other appropriate

intervals especially with changes in disease status (ie, remission, recurrence, or disease progression).

Treatment is determined on the basis of the level and source(s) of distress

identified. Clear roles are delineated for members of the primary oncology team as well as for psychosocial oncology professionals who deliver mental health services, social work

and counseling services, and chaplaincy services. [8]

In 2014, ASCO released evidence-based guidelines for managing depression and anxiety in patients with cancer.{ref 9} These

guidelines were adapted from the 2010 Pan-Canadian Practice Guideline: Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer, which was developed

as a synthesis of five practice guidelines, including the NCCN guidelines for stress management. [10]

The ASCO guidelines identify separate processes for screening, assessment, and

treatment of depression and anxiety in adults with cancer. Timing of evaluation, types of assessment tools, and specific treatment pathways are recommended depending on the levels

of symptoms reported. Recommendations for follow-up and ongoing re-assessment are also provided. [9]

Palliative Sedation

In 2009, the European Association of Palliative Care (EAPC) published

guidelines to address the key clinical issues surrounding palliative sedation. The recommendations in the guidelines are intended to be modified to reflect local culture; legal

considerations; and specific needs of the home, hospital, or hospice-based setting. The recommendations include the following [11] :

Sedation can be considered for patients

with intolerable distress due to physical symptoms and a lack of other methods of palliation

Continuous deep sedation should be considered only in the very terminal stages of

illness with expected death within hours to days at most

Evaluation should be performed by a clinician with expertise in palliative care; whenever possible, evaluation should be

multidisciplinary

Assessment should include estimates at to whether death is anticipated within minutes to hours, hours to days, days to weeks, or longer, and evaluation of the

patient’s capacity to make decisions about ongoing care; if decisional capacity is in doubt, evaluation by a psychiatrist may be required

For patients with decisional capacity, the

aims, benefits, and risks of the proposed sedation should be discussed with the patient and preferably with participation of family members

For patients lacking capacity to decide, and

without advance directives, permission should be obtained from a legally recognized proxy

In actively dying patients who have no advanced directive or health care proxy and

are in severe distress, comfort measures, including the use of sedation if necessary, is the standard of care

If the family members are not participants in the decision process, permission should be

sought to inform them of the decision

The level of sedation should be the lowest level necessary to provide relief of suffering

Intermittent or mild sedation should be

attempted first

The presence of refractory psychological symptoms does not necessarily indicate a far advanced state of physiological deterioration; sedation should be reserved for

patients in advanced stages of terminal disease under the following circumstances:

Symptoms should be designated as refractory only after repeated assessment

by clinicians with psychological treatment expertise who have established a relationship with the patient and family and have attempted routine approaches for anxiety, depression, and

existential distress

Evaluation should be conducted by a multidisciplinary team that includes psychiatrists, chaplains, ethicists, and persons providing direct care for the patient

In the rare cases where sedation is appropriate, sedation should be delivered on a respite basis for 6-24 hours with planned downward titration

Continuous sedation should be considered

only after repeated trials of respite sedation with intensive intermittent therapy

The 2014 European Society of Medical Oncology (ESMO) guidelines for use of palliative sedation in

advanced-stage cancer are derived from the EAPC guidelines and contain no major variances in the recommendations. [12]

NCCN guidelines for palliative sedation are also in general

agreement with EAPC. Additional specific recommendations include the following [2] :

Palliative sedation is best performed by palliative care experts

The patient must have

refractory symptoms that cannot be controlled despite aggressive palliative care that does not compromise consciousness, and death is anticipated within hours to days as

confirmed by two physicians

Reassignment of health care providers who cannot provide sedation due to personal or professional beliefs as long as patient care can

safely be transferred to another health care professional

Maintain current pain and symptom management interventions

Monitor patient symptoms and titrate

sedatives and other medications to maintain a level of sedation that relieves the patient's refractory symptoms

Provide ongoing psychosocial and spiritual support for the

patient’s family and health care providers

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